VERMONT

DOL FORM 15 (Rev. 5/05)

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

Fed. ID No. _____

DEPARTMENT OF LABOR
WORKER'S COMPENSATION DIVISION

SETTLEMENT AGREEMENT

It is hereby agreed by and between _____ the employee of the town of _____ and the state of _____, and _____ ****insurance carrier** **** employer**, by reason of an accidental injury suffered at _____ on _____, 20 _____ by the said employee while in the employ of _____ in the town of _____ and the state of _____ causing the following injury: _____ and resulting temporary total disability which began _____, 20 _____.

That the employee's average weekly wage for twelve weeks before the accident was $ _____

This is an agreement in which the claimant agrees to accept $ _____, in full and final settlement of all claims for injuries sustained as a result of the accident referred to above, including ****his** ****her** Claim for past, present and future compensation for temporary total disability, temporary partial disability, permanent partial disability or permanent total disability, dependency benefits, medical, hospital, surgical and nursing expenses, and vocational rehabilitation benefits.

APPROVAL AND REVIEW

This agreement or any settlement thereunder shall not be binding or operative unless and until this settlement agreement is approved by the Commissioner of Labor.

Dated at _____ this _____ day of _____, 20 _____

APPROVED: _____, 20 _____

_____
Insurance Carrier or Employer

_____
Commissioner of Labor/Designee

By _____

_____
Official Title

_____
Employee

_____
Witness

****Strike out inappropriate expressions.**